No. 88-1503

Supreme Court, U.S.
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IN THE
# Supreme Court of the United States
OCTOBER TERM, 1989

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NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,
*Petitioners,*
v.
ROBERT F. HARMON, Director of the Missouri Department of Health, *et al.*,
*Respondents,*
v.
THAD C. MCCANSE, Guardian Ad Litem,
*Respondent.*

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**On Writ of Certiorari to the Supreme Court of the State of Missouri**

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## BRIEF OF ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, AND C. EVERETT KOOP, M.D., Sc.D., JOHN ALLEN, M.D., WILLIAM J. BURKE, M.D., PHILIP R. CALANCHINI, M.D., CHRISTOPHER M. DeGEORGIO, M.D., MATTHEW E. CONOLLY, M.D., D. ALAN SHEWMON, M.D., PATRICK DERR, Ph.D., JOHN M. DOLAN, Ph.D., ARTHUR J. DYCK, Ph.D., ROBERT E. FLYNN, M.D., CALIXTO MASO, M.D., AND OTHERS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS *

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### INTEREST OF THE *AMICI*

The Association of American Physicians and Surgeons, Inc. (AAPS), a not-for-profit corporation, is the largest association of private practicing physicians in the United States. AAPS is comprised of active, practicing physicians and osteopaths of all specialties, from

every state and territory in the United States and the District of Columbia. One purpose of the AAPS is to protect and preserve the integrity of the private practice of medicine, and the ethical standards which define the profession. For these reasons, the issues involved in this case are of acute interest to the association.

The individual *amici* include a former Surgeon General of the United States Public Health Service, and professors in neurology and the humanities, all of whom share a special interest in the treatment of patients with severe neurological impairments, such as Nancy Cruzan. Many of these *amici* are members or fellows in the American Academy of Neurology ("AAN"), and the American Medical Association ("AMA"), which have filed briefs on behalf of the petitioners.

*Amici* desire to provide this Court a balanced and accurate view of the state of medical knowledge and opinion to inform its judgment in this case. The *amici* consider that the briefs filed on behalf of the AAN and the AMA have overstated both the certainty of scientific and medical knowledge regarding the persisent vegetative state (PVS), as well as the consensus of medical and ethical opinion regarding the appropriate means of treating patients in PVS. Furthermore, these briefs have disregarded the enormous potential this case holds for eroding societal prohibitions against assisted suicide and euthanasia.

Moreover, *amici* categorically reject the position that the duty of care to the patient in PVS is somehow diminished by the fact that the patient will not recover. Such a philosophy directly contradicts the binding commitment of the physician to the *well-being* of the patient, Specifically, patients such as Nancy Cruzan are not abstract interests, or symbols of a cause. Rather, they are persons with legitimate claims upon the human family in general, and medical science in particular. For a state to require that such patients in its own hospitals



be fed by non-burdensome means does no violence to standards of medical ethics, but is consistent with such standards.

*Amici* urge this Court to affirm the decision below.

## SUMMARY OF ARGUMENT

### I.

The decision of the Missouri Supreme Court proceeds from the sound assumption that advances in medical technology, and their attendant dilemmas, are no grounds for needless "innovations" in legal principle. This is particularly true where such innovations threaten fundamental rights, such as the right to life, and well-established legal strictures, such as the prohibition against mercy-killing and enuthansia.

Petitioners argue, however, for this Court to take three unprecedented steps: first, extend the protection of an incompetent person's substantive Due Process liberties to proxy decisionmakers; second, hold that such proxy decisions overcome the state's *parens patriae* authority to protect incompetent patients; and third, hold that the Constitution protects the decision to cause one's own death, and by implication, the death of one's ward. This Court has previously established the need for caution in determining whether a particular right should be accorded fundamental status. *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986). To take any one of these three steps, however, would throw caution to the winds, and revolutionize the carefully balanced scheme of state laws protecting incompetent persons.

The petitioners constitutional claims are not supported by reference to the common law. The relief sought by the family of Nancy Cruzan is opposed by at least one of her regular physicians, and by virtually the entire nursing staff of the Missouri Rehabilitation Center. The traditional legal approach in cases where interested parties

disagree over the treatment of an incompetent patient is to seek a judicial determination. Against the family's claims that it is in the best interests of their daughter to die, the Missouri court weighed the inconclusive testimony regarding her own wishes, the fact that the provision of nourishment is not burdensome to Nancy Cruzan, and the state's strong presumption in favor of sustaining life. This weighing of interests was consistent with the traditional approach of the common law and equity, far more so than the substituted judgment mechanism urged by the petitioners.

II.

The arguments on behalf of petitioner presume a medical and societal consensus that once a diagnosis of persistent vegetative state (PVS) is established, there is no obligation to take any measures to sustain the life of the patient. Furthermore, these arguments presume that removal of nutrition from PVS patients will not affect treatment decisions for other neurologically impaired patients, due to the unique characteristics of the persistent vegetative state. This argument ignores several countervailing factors. First, the argument is based inherently upon "quality of life" criteria, which are not within the peculiar realm of medical competence, and are opposed by many reasonable physicians and health-care providers. Second, PVS patients are not as easily segregated, in medical or ethical terms, from other impaired patients. PVS is at the extreme end of a continuum of neurological deficit, and it is quite likely that decisions in cases such as this will affect patients at other points on that continuum.

Third, a great deal is *not* known about PVS patients, and the conclusion that such patients have no cognitive function is inherently unverifiable, given the present state of medical knowledge. Fourth, although reports of recovery from PVS are rare, they have occurred, most notably in a recent case where a state judge had authorized withdrawal of the patient's nourishment. Since the medical



testimony in this case conflicted as to whether Nancy Cruzan is even in a persistent vegetative state, caution is in order. Finally, state cases have already extended the legal principles established in cases involving PVS patients to situations such as cerebral palsy, Batten's Disease, and short-term coma. It is clear that whatever precedent is set in this case may affect not only the estimated 10,000 PVS patients, but potentially, a wider population.

III.

The removal of nourishment implicates legal, medical, and ethical values that are not so clearly at stake in decisions to withdraw more burdensome forms of medical treatment. Here, the clear intent of stopping Nancy Cruzan's feeding is so that she will die. Such a decision is tantamount to mercy-killing, which is illegal, and contrary to the fundamental ethic of medicine. Justifying such a decision on the vague prior statements of Nancy Cruzan is legally and morally irresponsible. When viewed in terms of burden to this patient, it is clear that the provision of nourishment is non-burdensome, and thus, should continue to be provided. Allowing the removal of non-burdensome means of nourishment based upon a quality of life judgment compromises the obligation of care that is owed to every patient, regardless of disability or impairment.

## ARGUMENT

### I. NEITHER THE FEDERAL CONSTITUTION NOR THE COMMON LAW CONFER A RIGHT UPON THIRD PARTIES TO INTENTIONALLY CAUSE THE DEATH OF AN INCOMPETENT PATIENT.

#### A. The Right Asserted by the Petitioner Is Foreign to the Jurisprudence of Personal Liberty Under the Due Process Clause of the Fourteenth Amendment.

1. The analogies drawn by the petitioners between the removal of Nancy Cruzan's nourishment, and the unenumerated "liberties" heretofore protected by this Court, are wholly inapt. Medical treatment decisions,

like those pertaining to marriage, family, and education, are among the most personal and life-defining that a person can make. Accordingly, "the course of action that will best promote the patient's well-being rests on subjective judgments *that only the patient is in a position to make.*" [1] Here, the patient is incapable of any judgments, subjective or otherwise, and, as the Court below found, the evidence of her prior statements was insufficient to draw any conclusion as to what she would choose to have done in the current situation. *Cruzan* v. *Harmon*, 760 S.W.2d 408, 424 (Mo. 1988), *pet. for cert. granted*, No. 88-1503.[2]

Thus, the petitioners are compelled to argue for the first of three revolutionary steps: the extension of substantive due process rights under the Fourteenth Amendment to third-party, proxy decision-makers. None of the "privacy" or "unenumerated rights" cases of this Court have ever made such rights transferable to another person. The constitutional protection granted by this Court to decisions such as whom to marry,[3] whether to beget children,[4] and how to educate those children,[5] presumed

[1] Brief of the American Medical Association, *et al.*, as *Amici Curiae*, at 23, n.29 (emphasis supplied).

[2] Despite the findings of the trial court, the evidence in this case can support no other conclusion. Nancy Cruzan left no "living will" or other document setting forth her wishes. In conversations with family and friends, she never specifically discussed the withdrawal of medical care or treatment. *See* Tr. 451 (testimony of Joseph Cruzan); Tr. 527 (Joyce Cruzan); Tr. 538, 541, 551 (Christy White); Tr. 562 (Tammy Sue Benson). Petitioners' and *amici*'s arguments that Nancy's desire would be to withdraw feeding are based upon her previously vivacious and independent lifestyle, not upon specific statements of intent. While such considerations may be relevant in making a treatment decision, they do not rise to the level of an informed refusal of treatment.

[3] *Loving v. Virginia*, 388 U.S. 1 (1967).

[4] *Skinner* v. *Oklahoma*, 316 U.S. 535 (1942); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).

[5] *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925).



that these decisions were to be made by competent persons. No decision of this Court has vested guardians or other proxy decision-makers with the right to make such decisions on behalf of an incompetent person.[6] Nor are the rights conferred above absolute.[7]

Where a person is incapable of exercising her asserted "liberty" to refuse treatment, the rationale for extending *constitutional* protection to removal of that treatment is no longer present. The patient's rights have not diminished; rather, she has lost the ability to exercise a treatment choice in such a manner that her Fourteenth Amendment rights could be invoked. The law is obligated to ensure to the best of its ability that decisions made on behalf of the incompetent are in her best interests. Dispute may arise, as it has here, over what constitutes "best interests." However, attempting to defer responsibility for that decision by imputing a will to die to the incompetent patient is an irresponsible extension of the moral notion of "autonomy," and the constitutional protection of "liberty" under the Fourteenth Amendment.[8]

The petitioners and *amici* also misconstrue the character of the Fourteenth Amendment liberties they claim to advance. These liberties do not protect a particular action *per se*, but rather, the individual's freedom to choose among alternatives. Thus, even under *Roe* v. *Wade*, 410 U.S. 113 (1973), the liberty of the woman to

[6] Indeed, legislative attempts to give third parties decision making authority in matters held to be protected by the Due Process clause have been invalidated. *See, e.g., Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (spousal and parental consent requirements relating to abortion).

[7] *See, e.g., Prince v. Massachusetts*, 321 U.S. 159, 167 (1944) ("neither rights of religion nor rights of parenthood are beyond limitation"). *Compare Loving v. Virginia*, 388 U.S. 1, with *Reynolds v. United States*, 98 U.S. 145 (1879).

[8] *See* Arkes, *"Autonomy" and the "Quality of Life,"; The Dismantling of Moral Terms*, 2 Issues in Law & Med. 421, 427-428; Tribe, *American Constitutional Law*, § 15-11, p. 1368, n. 25 (1988).

choose childbirth is at least equal to her right to choose abortion. *Maher* v. *Roe*, 432 U.S. 464 (1977). Similarly, the right of Nancy Cruzan to choose to continue to live is at least as strongly protected by law as her right to refuse medical treatment. Her right to change her mind regarding such decisions, or to make a decision that might seem idiosyncratic to some, is likewise secured.

2. It is precisely to ensure that all such rights and interests are recognized that the state asserts its plenary authority of *parens patriae* over guardians. Thus, the relief sought by petitioners seeks a second revolutionary alteration in Fourteenth Amendment jurisprudence: employing the Due Process clause to limit the supervisory authority of states over decisions by guardians whom the state itself has appointed. The circumstances of this case illustrate just how extreme a result this would be. The parents of Nancy Cruzan were permitted to bring forward all relevant evidence and arguments in support of their petition. A *guardian ad litem* was appointed, and a full evidentiary hearing held. Against the family's claims that it would be in Nancy Cruzan's best interests to die, the court below weighed the inconclusiveness of her prior statements on the question, the non-burdensome nature of the tube feeding that sustains her life, and the strong state presumption in favor of the preservation of life.

In essence, the petitioners are asking for this Court, under the guise of the Fourteenth Amendment, to sit in review of the Missouri court's exercise of the *parens patriae* power. This would constitute a seismic breach in the principle of federalism, and open this Court to sit as a national court of chancery, resolving claims that state guardianship proceedings have violated fundamental rights.[9] It would likewise impair the authority of the

[9] For example, under the logic of this petition, virtually any medical treatment decision or other action involving the person of the incompetent ward could be the subject of federal court review, on the theory that the ward's constitutional right to have the issue determined differently has been violated. This is not to say



states to regulate the issues raised by this case through legislation. Indeed, the relief sought here could potentially affect all state legislation on subjects ranging from the "living will" to brain death.[10]

that some decisions of a state court, acting as *parens patriae*, may so egregiously violate the procedural or substantive rights of the incompetent so as to necessitate this Court's review. What sets this case apart, however, is the essential impossibility of determining how Nancy Cruzan, in her present circumstances, would choose to exercise the right asserted on her behalf. In the face of this dilemma, the court below determined to opt in favor of life, a result which is consistent with Nancy's explicit rights under the Fourteenth Amendment, and with the common law presumption in favor of sustaining life. *See, In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

[10] State "living will" or "natural death" legislation attempts to define the conditions under which a written advance directive from a previously competent patient will immunize decisions to withdraw life-sustaining treatment from the patient once she becomes incompetent. *See generally*, A. Meisel, *The Right to Die* 355-377 (1989). Such conditions include the medical diagnosis and prognosis of the patient, and the type of treatment that may be withdrawn. *Id.* at 365-377. Establishment of a constitutional right of guardians or family members to make such decisions would provide an effective end-run around such statutes.

Statutory definitions of death have attempted to resolve the medico-legal controversy arising from medicine's ability to sustain heart and lung function past the point where the patient has retained *any* brain function, including brain stem function, and the abilities spontaneously to breathe and to circulate blood have been permanently lost. *See generally*, Korein, *The Problem of Brain Death: Development and History*, 315 Annals N.Y. Acad. Sci. 21 (1978); President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research, *Defining Death* (1981). The legislative consensus emerged in support of the Uniform Determination of Death Act ("UDDA"), providing that "[a]n individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead." *Id.* at 73. Patients in a persistent vegetative state are not "brain dead." However, a ruling by this Court that, as a matter of constitutional law, all nourishment can be withdrawn from such patients, would have the practical effect of amending the UDDA so as to permit PVS

3. The third "revolution" that would be accomplished by overturning the decision below is creation of a substantive "right to die" under the Fourteenth Amendment. This right knows no precedent in the jurisprudence of this Court, and once established, would know virtually no limits. The matter before this Court does not concern the merits of one course of medical treatment over another, hospice care versus hospital care, or whether aggressive therapy should be continued in the face of inevitable death. Rather, it concerns the desire a family, admittedly based upon its own assessment of the patient's quality of life, that the patient's life should come to an end.[11] This Court has never even considered whether *competent* persons have the right to make such a judgment for themselves; surely there is no justification for the more dramatic step of granting such a right to family members.

Creation of such a right, particularly in the circumstances set forth here, would also threaten the specific protection of the right to life under the Due Process Clause. Not only would incompetent patients be deprived of their lives; their "guardians" would enjoy the constitutional privilege to make such decisions, free of state supervision. *See* Destro, "Quality of Life Ethics and Constitutional Jurisprudence: The Demise of Natural Right and Equal Protection for the Disabled and Incompetent," 2 J. Contemp. Health Law & Policy 71 (1986) Petitioners deny that such a "slippery slope" is at issue in this case.[12] Yet, the logic of their argument—that decisions

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patients to be treated as "virtually dead." The bright line which the drafters of the UDDA sought to draw between patients who have permanently lost all function of the entire brain, and those who retain brain stem function, would be lost. *See*, Capron, *Anencephalic Donors: Separate the Dead from the Dying*, 17 Hastings Center Rep. 5 (Feb. 1987).

[11] *See* Brief for Petitioners at 38; Tr. at 444 (testimony of Joseph Cruzan).

[12] Brief for Petitioners at 38.



by family members to withdraw medical treatment from incompetent patients should be protected as a constitutional right—places that issue squarely before this Court.[13]

In conclusion, creation of a constitutional right to withdraw nourishment from a patient in PVS finds no precedent in the decisions of this Court, would unduly intrude upon well-established principles and procedures of state guardianship law, and would compromise protection of the right to life of incompetent patients. Furthermore, it would inevitably involve this Court in complex line-drawing regarding the precise boundaries of this "right." Tragic though the circumstances of this case may be, they do not justify this Court embarking on such a risk-laden venture in constitutional jurisprudence.

**B. The Common Law Right to Refuse Medical Treatment Does Not Confer Upon Guardians a Right to Make Decisions, the Intention of Which Is to Cause the Death of an Incompetent Person.**

Petitioners contend that the right to refuse medical treatment is deeply rooted in the common law, and provides further support for their claim of a "fundamental"

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[13] Petitioners argue that the "slippery slope" of patient abuse is not at issue because "[o]ur Constitution stands as a bastion of protection for individuals against such abuse by the State." Brief for Petitioners at 38. Professor Kamisar, however, has noted the myopic nature of such assertions, and their failure to recognize the price that must be paid for such security under our Constitution.

> It can't happen here. Well, maybe it cannot, but no small part of our Constitution and no small number of our Supreme Court opinions stem from the fear that *it can happen here unless we darn well make sure that it does not* by adamantly holding the line, by swiftly snuffing out what are or might be the small beginnings of what we do not want to happen here. To flick off . . . the fears about legalized euthanasia as so much nonsense, as a chimerical "parade of horrors," is to sweep away much of the ground on which all our civil liberties rest.

Kamisar, *Some Non-Religious Views Against Proposed Mercy-Killing Legislation*, 42 Minn. L.Rev. 969, 1038 (1958).

right to withdraw nourishment.[14] However, decisions establishing the common law right of a *competent* adult to decline medical treatment are of limited relevance to this case.[15] Far more relevant is the legal tradition regarding decision-making for *incompetent* patients, and the limits placed upon the authority of surrogate decision-makers.

The centuries-old response of the law to situations such as that presented here has evolved into the current practice of appointing conservators, committees of the person, or guardians to represent the interests of incompetent persons.[16] The *parens patriae* power of the courts "derives from the inherent equitable authority of the sovereign to protect those persons within the state who cannot protect themselves because of an innate legal disability." [17] As held by the court below, the authority of

[14] Petitioners rely on *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250 (1891), in which this Court refused to compel a personal-injury plaintiff to submit to a medical examination, as establishing a fundamental liberty against unwanted medical intrusions. Yet, as *Botsford* recognized, this liberty may be modified by a "clear . . . authority of law." 141 U.S. at 251. Thus, in *Sibbach v. Wilson & Co.*, 312 U.S. 1 (1941), this Court held that pursuant to then-Rule 35 of the Federal Rules of Civil Procedure, a plaintiff could be ordered to undergo an examination by a physician retained by the defense. In *Schlagenhauf v. Holder*, 379 U.S. 104 (1964), this holding was extended to defendants, and the Court recognized that Rule 35 cannot be successfully attacked on constitutional grounds, such as invasion of privacy. *See also, Sibbach*, 312 U.S. at 17 (Frankfurter, J., dissenting) ("[t]o be sure, the immunity that was recognized in [*Botsford*] has no constitutional sanction. It is amenable to statutory change.")

[15] For further discussion of the history and scope of the common law right to refuse medical treatment, *see* Brief of Focus on the Family and Family Research Council, *et al.*, as *Amici Curiae* in Support of Respondents.

[16] For a further discussion of this history, *see* Brief *Amici Curiae* of Association of Retarded Citizens of Ameica, *et al.*, in Support of Respondents.

[17] *In re Grady*, 85 N.J. 235, 259, 426 A.2d 467, 479 (1981).



guardians to make decisions on behalf of incompetent persons derives from this *parens patriae* power, and is exercised subject to the supervision of the courts. 760 S.W.2d at 425.[18] The need for court intervention and supervision is particularly acute where, as here, there is profound disagreement between the family of Nancy Cruzan, and those caring for her, on the issue of withdrawing nourishment.[19]

Petitioners disregard the historical foundations of the guardian's authority to render decisions on behalf of the incompetent. Traditionally, the full deference given to the informed consent or refusal of a competent patient has not been granted to the decision of a surrogate, no matter how well-motivated that surrogate might appear to be.[20] Thus, the court rejected the assertion that the guardian's

[18] This does not mean that formal appointment of a guardian is required for *all* decisions to withdraw medical treatment from an incompetent person, or that all such decisions must be approved by a court. The decision below stands for no such proposition. As noted in the Brief *Amici Curiae* of SSM Health Care System, *et al.*, such issues generally need not be resolved in court if decision-making processes which take into account the fundamental principles of guardianship law are followed. *Id* at 18-19. However, the "state probate or equity court must be available" to hear challenges to the decision-making process, *Id.* at 18, which is precisely the situation here. The evidence demonstrates that those who oversee and provide the care received by Nancy Cruzan disagree, in some instances strongly, with the family's request. *See* note 19, *infra*. Their objection is consistent with the fundamental tenet of guardianship law that decisions be made for the welfare of the incompetent person. It is clearly reasonable for these parties to contend that since it will result in her inevitable death, removal of Nancy's feeding is not a benefit to her.

[19] The record establishes that virtually the entire nursing staff of the Hearnes 4 unit, as well as Dr. Isaac, a medical supervisor of the unit, oppose the family's request. Tr. 378, 646-647, 619, 666-668, 673-689. Where such conflict exists, "serious consideration must be given to seeking the judicial appointment of a guardian." A. Meisel, *The Right to Die*, 165 (1989).

[20] Meisel, *supra* note 19 at 260.

authority flows from the patient's own constitutional and common law rights. 760 S.W. 2d at 425. Rather, the guardian's authority to exercise a third-party choice on behalf of a ward arises from the guardian's status as the delegatee of the state's power of *parens patriae*. *Id.* at 425-426.[21] As such, this authority remains subject to court supervision. *Grady*, 85 N.J. at 264, 426 A.2d at 482.

In essence, the petitioners' argument is that this Court should extend the protection of the Fourteenth Amendment to decisions made by "substituted judgment." New York's highest court recently rejected that doctrine in a similar case and noted its profound limitations:

> That approach remains unacceptable because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another . . .[D]espite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.

*Matter of Westchester County, Medical Center (O'Connor)*, 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988).[22] The court thus affirmed its reliance

[21] *Accord, In re Conroy*, 98 N.J. 321, 364, 486 A.2d 1209, 1231 (1985) ("[I]n the absence of adequate proof of the patient's wishes, it is naive to pretend that the right to self-determination serves as the basis for substituted decision-making.")

[22] The ultimate fallacy of "protecting" an incompetent patient's right to refuse treatment by the "substituted judgment" mechanism is that it attempts to shift the locus of decisionmaking authority to a patient who simply cannot decide for herself. *See* R. Burt, *Taking Care of Strangers: The Rule of Law in Doctor-Patient Relationships* 152 (1979) (criticizing *Quinlan*'s employment of substituted judgment). "[T]he notion of substituted judgment is logically contradictory. Simply put, autonomy and self-determination refer to the individual's freedom to choose. If a third party, no matter how well-intentioned, makes a choice for that individual, the choice can no longer be called autonomous."



upon the standard of clear and convincing evidence in determining whether a patient would, if competent, request treatment to be withdrawn.

The decision below, in rejecting substituted judgment, also manifested an appropriate caution, consistent with common law jurisprudence, in evaluating testimony of an incompetent person's prior statements. As the court recognized, it is often difficult to discern where the patient's purported wishes end, and the wishes of the family begin. The reported statements of Nancy Cruzan, far from being the type of statements characteristic of informed consent, are expressions of a universal fear of human frailty and dependence. Other courts, faced with similar statements, have refused to find in them sufficient evidence of the patient's intent.[23] Clearly, no one would choose to be cognitively impaired as is Ms. Cruzan. Some might consider it a fate worse than death itself. Yet, the same might be true of a broad range of neurological impairments, not limited to the persistent vegetative state. Law and medicine cannot premise decisions which will inevitably cause death upon such universal fears and emotions, and then defend such decisions as "informed consent." As New York's highest court noted in *O'Connor*, "[e]veryone has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances." 72 N.Y.2d at 530-31, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

The decision below finds far more support in the traditions of the common law and equity than does the relief

Ikuta, *Dying at the Right Time: A Critical Legal Theory Approach to Timing-of-Death Issues*, 5 Issues in Law & Med. 3, (1989).

[23] *O'Connor*, 72 N.Y.2d at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893; *In re Jobes*, 108 N.J. 394, 529 A.2d 434, 443 ("the statements about life-support that were attributed to Ms. Jobes were remote, general, spontaneous and made in casual circumstances. Indeed, they closely resemble the examples of evidence that we have explicitly characterized as unreliable.")

proposed by the petitioners. Accordingly, it should be affirmed.

## II. A DIAGNOSIS OF PERSISTENT VEGETATIVE STATE IS NOT AN ADEQUATE PRETEXT FOR WITHDRAWING FOOD AND WATER FROM A PATIENT.

Although the relief sought by the petitioners would, in theory, extend to a wide range of incompetent patients, the poignancy of this case is heightened by the diagnosis of Nancy Cruzan in a persistent vegetative state ("PVS").[24] Although there has been some confusion regarding this term, there are recognized clinical indicia that are typical of this state:

> These include spontaneous eye opening, return of sleep/wake cycles, spontaneous maintenance of blood pressure and regular respiratory pattern, lack of discrete localizing motor responses, absence of comprehensible vocalization, inability to obey commands, and lack of sustained visual pursuit movements. Thus, the patient is described as wakeful, but devoid of conscious content, without cognitive or affective mental function.[25]

A patient with PVS, therefore, shows no *evidence* of cognitive function, and brain function is limited to upper brain-stem activity controlling respiration, circulation, and reflexes.

As a seminal study of this syndrome acknowledged, the ethical issues of treating such patients are not unrelated to the issues of treating patients who are cognitively impaired, but show some evidence of limited brain function:

[24] While *amici* do not contest the state court findings in this regard, it is noteworthy that two of the four physicians who testified at trial did not consider Nancy Cruzan to be in a PVS. *See* Tr. 679-696 (testimony of Anita Isaac, M.D.) and Tr. 750-764 (James Dexter, M.D.).

[25] Berrol, *Consideration for Management of the Persistent Vegetative State*, 67 Archives of Physical Med. and Rehabil. 283 (1986).



> It may well become a matter for discussion how worthwhile life is for patients whose capacity for meaningful response is very limited, but it still seems to us that the immediate issue is to recognize that there is a group of patients who never show evidence of a working mind.

Jennett and Plum, *Persistent Vegetative State After Brain Damage: A Syndrome in Search of a Name*, Lancet, 734, 737 (1972). Many conscientious neurologists and other physicians conclude that once a reliable diagnosis of PVS is rendered, and adequate time has passed to confirm that diagnosis, some measures of life-support may be withdrawn from the patient. This conclusion is based on the severity of the disorder, the lack of hope for recovery, and the burdensomeness of the treatment in question.

However, the decision whether to remove food and water from such patients remains more controversial.[26] It is not true, as claimed by several *amicus* briefs submitted on behalf of the petitioners, that there is a clear consensus in the medical community to support withdrawl of food and water from patients such as Ms. Cruzan.[27] The degree of certainty with which some individuals and groups—including some participating in this case as witnesses or *amici*—express this "consensus" is misplaced, for several reasons.

First, the firm conclusion of some ethics statements that food and water may be withdrawn from patients

[26] For example, a position paper on withdrawal of treatment from the Stanford University Medical Center Committee on Ethics acknowledges that the "withdrawal of basic life support, such as hydration or nutrition by intravenous lines or feeding, is ethically controversial and complex. Although most people eventually feel at peace with stopping more technical interventions, these basic measures are regarded more as signs of caring than of treatment." Ruark, *et al., Initiating and Withdrawing Life Support*, 318 New Eng. J. Med. 25, 30 (1988).

[27] *See* discussion in Section III of this Brief.

reliably diagnosed in PVS is not a medically verifiable proposition. Such statements, including those of the American Medical Association (AMA)[28] and American Academy of Neurology (AAN),[29] provide an accurate description of PVS, and the dim prognosis of the patient in such a state. However, their subsequent and equally certain conclusion that feeding may be withdrawn in such cases is a leap of logic from the realm of medical science into the realm of philosophy and public policy. These statements have apparently drawn the conclusion that the quality of life for a patient in PVS is so poor that further treatment, even nourishment, may not be appropriate. This conclusion may be supported by well-motivated social, ethical, and even economic concerns. However, these are not matters of peculiarly scientific or medical competence, and the judgments expressed therein are simply one in a range of ethical approaches to the subject.[30] Accordingly, the authors of such statements are simply not competent to express a binding societal or even medical consensus on this difficult question. State courts and legislatures, on the other hand, are uniquely competent to determine whether such decisions are lawful.

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[28] American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment*, Current Opinions of the Council on Etthical and Judicial Affairs, Opinion 2.18 (1986).

[29] American Academy of Neurology, *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, Neurology 39:125 (1989).

[30] The leadership of the AAN professes to acknowledge "that legitimate differences of opinion exist in society and among [AAN] members on the issues addressed in this statement—especially on the moral propriety of withdrawing artificial nutrition and hydration." Munsat, Stuart & Cranford, *Guidelines on the Vegetative State: Commentary on the American Academy of Neurology Statement*, Neurology 39:123 (1989). The AAN's position in this case, that there is virtually no obligation of care to a patient in PVS, is at odds with this pluralism among its *own membership*, and society at large.



Second, the diagnosis of PVS is properly understood as part of a *continuum* of neurological deficit and interaction with the environment. While PVS is at the extreme end of this continuum, it is similar in physiology and phenomenology to related states such as akinetic mutism, multi-infarct dementia or other advanced dementing processes. Furthermore, the technique of diagnosis is demanding, and expert neurologists may disagree in particular cases. In this case, for example, the three neurologists who examined Nancy Cruzan shortly prior to giving depositions or courtroom testimony each offered a somewhat different diagnosis of her condition, and two, Drs. Wong and Dexter, did not concur with Dr. Cranford's diagnosis of PVS. Tr. 764 (Dr. Dexter); Tr. 125 (Dr. Cranford); Tr. 835 (Dr. Wong). Furthermore, the consistent and uncontroverted testimony of the nurses who provide daily care for Nancy is that she exhibits a low level of response that is inconsistent with the absolute lack of responsiveness that is supposed to characterize PVS. Tr. 617-618 (Nurse Rowell); Tr. 642-650 (Nurse Bowker); Tr. 591-607 (Nurse Johnson); Tr. 372-374 (Nurse Perrin).

If the decision below is overturned, such borderline cases are likely to be resolved by allowing the withdrawal of feeding. The question then becomes, at what point should the law draw a firm line and refuse to permit the starvation of the patient. Reversal of the decision below will lead to speculation, and litigation, as to whether the Constitution protects decisions to withdraw nourishment from other classes of patients. Hence, this Court can expect to be faced with petitions from families of patients with severe dementia of the Alzheimer's type, hydranencephaly, and profound mental retardation.[31]

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[31] This problem cannot be realistically avoided by attempting to artificially segregate patients with PVS from all other patients on the continuum of neurological deficit. Nothing within the realm of medical knowledge can provide a principled basis for permitting withdrawal of nutrition in the case of PVS, but not permitting it

Third, the boldness of certain pronouncements regarding treatment of PVS patients masks the fact that there is a great deal that is *not* known concerning such patients. It is medically correct to state that where an accurate diagnosis of PVS has been [illegible] is no *apparent* cognitive function. However, the conclusion that no such function is *present* is inherently unverifiable, given the current state of medical knowledge. For example, the potential range of internal affective or emotional function in PVS patients is largely a mystery. In addition, no large-scale systematic studies correlating the clinical diagnosis of PVS with post-mortem findings have been completed. Such studies would be useful to verify the accuracy of current means of clinical diagnosis.

Furthermore, categorically ruling out the possibility of awareness on the part of patients who are *thought* to be in PVS or coma may have a self-fulfilling impact. *See*, LaPuma, Schiedermayer, Gulyas, and Siegler, "Talking to Comatose Patients," 45 Arch. Neurol. 20 (1988) ("*not* talking to comatose patients may well promulgate the notion that these patients are dead or nearly dead, and promote the inappropriate withholding or withdrawal of therapy. While we believe it is ethically permissible to withhold or withdraw therapy in certain situations, withholding speech should not make these decisions inevitable.")

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in related conditions. Indeed, it seems disingenuous for either the AMA or the AAN to make such an assertion. The AMA Judicial Council opinion which permits the withdrawal of nutrition makes no mention of the persistent vegetative state, but rather, refers to patients who are terminally ill, or in irreversible coma. *See* Opinion cited at n. 29, *supra*. Furthermore, one of the principal architects of the AAN statement, Dr. Cranford, has co-authored an article in which the withdrawal of nutrition was discussed for a range of patients not limited to those in PVS, *see* Wanzer, *et al., The Physician's Responsibility to the Hopelessly Ill Patient*, 310 New Eng. J. Med. 955 (1984), and a follow-up article clearly stating that it is not immoral for a physician to assist in the suicide of a terminally-ill patient. Wanzer, *et al., The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844, 848 (1989).



Fourth, the potential for recovery of patients who have been erroneously diagnosed in PVS, or have been diagnosed as having closely-related states of neurological deficit, should temper any broad grant of authority to guardians, family members, or physicians to withdraw nourishment once the diagnosis is rendered. In one recent case, an 86-year old woman regained consciousness and began speaking just two days after a New York court had found her to be in PVS, and ordered that her gastrastomy feeding tube could be removed. *In the Matter of Application of Gannon*, No. 0189-017460 (Supreme Ct., Albany County, April 3, 1989); *see*, Steinbock, *Recovery from Persistent Vegetative State?: The Case of Carrie Coons*, Hastings Center Rep. at 14-15 (July/Aug. 1989). Such accounts of recovery or improvement are not unknown in the medical literature. *See, e.g.*, Shuttleworth, *Recovery to Social and Economic Independence From Prolonged Post-anoxic Vegetative State*, 33 Neurology 372 (1983); Rosenberg, et al., *Recovery of Cognition After Prolonged Vegetative State*, 2 Ann.Neurol. 167 (1977); Higashi, et al., *Epidemiological Studies on Patients with a Persistent Vegetative State*, 40 J. of Neurol., Neurosurg., and Psychiatry, 876 (1977).

Although the accuracy in the diagnosis of PVS may improve, it is difficult to conceive of a workable medicolegal standard which would permit the starvation of patients diagnosed with PVS, or "permanent coma," without some risk that patients with potential for some improvement or recovery may also lose their lives. Obviously, the potential for error cannot be used to paralyze all medical decision-making regarding such patients. However, this risk should remind this Court that the decision to permit death by starvation of these patients is a serious matter, and that the objections to such a course are far more than merely "symbolic."

Fifth, however significant and verifiable a diagnosis of PVS may become in a clinical sense, medical science cannot expect the law to honor all of the technical nuances which distinguish this state from other profound impair-

ments. In the realm of law and public policy, a judgment that the quality of life of the PVS is so poor that there is no state interest in sustaining such a life may easily be applied to patients with related conditions. Courts have already considered the withdrawal of nourishment from patients who do *not* meet the criteria of PVS. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (cerebral palsy resulting in quadriplegia); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445 (Wash. 1987) (en banc), *change in listing of concurring Justices*, 757 P.2d 534 (1988) (Batten's disease); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (coma of five days' duration).

The decision whether to permit starvation of patients in PVS cannot be resolved adequately by physicians, families and institutions alone, but rather, lies as well within the province of legislatures and courts. Missouri's decision that starvation of Nancy Cruzan is not in her best interests, and poses risks to other patients, is consistent with this reality.

## III. NON-BURDENSOME ASSISTED FEEDING IS DISTINGUISHABLE FROM BURDENSOME FORMS OF MEDICAL TREATMENT.

Nancy Cruzan's sole continuous means of life support is the gastrostomy tube through which she receives her nourishment. More highly invasive and complicated measures such as mechanical ventilation, cardiopulmonary resuscitation, and renal dialysis are simply not at issue. Moreover, the record is clear that the task of providing Nancy with food is uncomplicated and routine, and does not require intervention by her physicians. Tr. 684, 689.

Despite this evidence, petitioners and *amici* address this case as if Nancy Cruzan's life were being sustained, against her will, by a sophisticated array of medical technology. In particular, *amici* AMA and AAN assert that there is no basis for distinction between nutrition and hydration, and other forms of life-sustaining medical



treatment, and they emphasize the *potential* complications of tube feeding—notwithstanding the fact that no such complications are present in this case. Furthermore, the petitioners and *amici* assert that the decision below is without precedent in American law, ignoring the array of federal and state statutes which recognize the very distinction which they deny. Finally, they ignore the substantive distinctions recognized by many physicians and medical ethicists between the withdrawal of nourishment, and the removal of more invasive forms of life support.

### A. The Decision Below Is Consistent With Statutes and Caselaw Which Recognize that the Withdrawal of Non-Burdensome Means of Nourishment Is Legally and Ethically Distinct from the Withdrawal of Burdensome Forms of Medical Treatment.

In recent years, approximately 40 states have enacted statutes giving legal effect to written declarations of a person's desires regarding medical treatment in the event that he or she becomes incompetent and terminally ill. A vast majority of these statutes draw an explicit or implicit distinction between removal of nutrition and hydration, and removal of other forms of medical treatment.[32] The majority below, along with the highest courts of Washington and New York, has drawn the same distinction. Federal statute and regulations concerning the medical treatment of handicapped infants do the same.[33] Petitioners and their allied *amici* virtually ignore this body of law.

Court decisions illustrates several jurisprudential grounds for treating nutrition and hydration separate from other forms of treatment. The first such reason is

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[32] *See* Grant & Forsythe, *The Plight of the Last Friend: Legal Issues for Physicians and Nurses in Providing Nutrition and Hydration*, 2 Issues in Law & Med. 277, 282, n.16 (1987); Brief of Focus on the Family and Family Research Council as *Amici Curiae* in Support of Respondents at 23-25.

[33] 42 U.S.C. § 5102(3) (Supp. III 1985); 45 C.F.R. § 1340.15(b)(2) (1987).

expressed by the Washington Supreme Court: that permitting nourishment to be withdrawn from a patient with Batten's disease is "pure, unadorned euthanasia," and would be "in direct conflict with this court's duty to preserve life." *In re Grant*, 109 Wash. 2d at 570, 747 P.2d at 458, *listing changed*, 757 P.2d 534 (Anderson, J., concurring and dissenting, *id.* at 575, 747 P.2d at 460 (Goodloe, J., dissenting). The identical reasoning has been expressed by several jurists who have dissented from their courts' endorsement of the withdrawal of nourishment from PVS patients. *See Brophy* v. *New England Sinai Hospital*, 398 Mass. 417, 497 N.E.2d 626, 640-646 (Nolan, J., Lynch, J., and O'Connor, J., dissenting); *In re Gardner*, 534 A.2d 947, 957-958 (Maine, 1987) (Clifford, J., dissenting). Reversal of the decision below would weaken the fabric of legal restrictions against euthanasia, already under direct attack in several states.[34]

In *O'Connor*, the New York Court of Appeals offered a second, no less compelling basis for distinguishing between nourishment and more complex forms of life support: that general statements about not wanting to be kept alive by "machines" do not mean that the patient would not want to be fed. The court thus rejected such general statements as adequate evidence of an intention to decline nourishment.

> If such statements were routinely held to be clear and convincing proof of a general intent to decline all medical treatment once incompetency sets in, few nursing home patients would ever receive life sustaining medical treatment in the future. The aged and infirm would be placed at grave risk if the law uniformly but unrealistically treated the expression of such sentiments as a calm and deliberate resolve to decline all life sustaining medical assistance once the speaker is silenced by medical disability."

72 N.Y.2d at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.

A third reason is provided by the evidence in this case, that when viewed in terms of burden to the patient, nutrition and hydration are distinct from other forms of treatment.

> If the testimony at trial that Nancy would experience no pain even if she were allowed to die by starvation and dehydration is to be believed, it is difficult to argue with any conviction that feeding by a tube already in place constitutes a painful invasion for her. And common sense tells us that food and water do not treat an illness, they maintain a life.
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> * * * *
>
> The issue is not whether the continued feeding and hydration of Nancy is medical treatment; it is whether feeding and providing liquid to Nancy is a burden to *her*. . . . We refuse to succumb to the semantic dilemma created by medical determinations of what is treatment; those distinction ofter prove legally irrelevant. For the reasons stated, we do not believe the care provided by artificial hydration and nutrition is oppressively burdensome *to Nancy* in this case.

760 S.W.2d at 423 (Emphasis in original) (citations omitted).

Petitioners understandably rely on the decisions in *Brophy* and *Gardner*, as well as *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987), all of which held nutrition and hydration to be burdensome medical treatment. These decisions are flawed, however, by their failure to assess, in any rigorous fashion, the burdens imposed and benefits derived from the continuation of nutrition in the particular case at hand. Rather, they have generally character-

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[34] *See* Hemlock Quarterly, July 1989 (discussion of National Hemlock Society efforts to legalize "physician aid-in-dying" through initiative and referendum in three states: Oregon, Washington, and California). Such proposals, for the time being, are limited to mercy-killing upon the request of a *competent* patient. However, establishment in this case of a constitutional right on the part of third parties to withdraw nourishment would be a predicate for later arguments that could obliterate the distinction between "voluntary" and "involuntary" euthanasia. *See* P. Ramsey, *Ethics at the Edges of Life* 294 (1978).

ized nutrition and hydration as "potentially burdensome" without determining whether the burdens to which they refer are actually being suffered by the patient whose treatment is at issue. The same errors are made by the petitioner.

It is now widely held that burdensome treatment can be withdrawn or withheld in situations where there is no overriding benefit. The integrity of this standard is compromised, however, when the particular facts of the patient's case are not assessed, and the substantial benefit of sustaining the patient's life is entirely discounted.[35] The standard is also weakened when the burdens side of the equation is padded by speculative, psychological concerns that are entirely unverifiable and subjective in nature.[36] Thus, the arguments of petitioners and their allied *amici* in favor of the burdens/benefits, or "proportionality" standard, are undercut by their failure to employ the standard in a meaningful fashion. Proper evaluation of the burdens of a treatment cannot be glossed over with generalities, or compromised by consideration of burdens that do not actually fall upon the patient. To do so renders the burdens/benefits calculus useless as an analytical tool.

**B. Creation of a Constitutional Right to Withdraw Nourishment from Incompetent Persons Will Have Profound Negative Consequences Upon Fundamental Axioms of the Medical Profession.**

The removal of nutrition and hydration, under medical supervision, is an act with profound consequences for the physician-patient relationship. The broader societal implications of allowing such removal further threaten that relationship. *See* May, et al., *Feeding and Hydrating the*

[35] *See* Horan & Grant, *The Legal Aspects of Withdrawing Nourishment*, 5 J. Leg. Med. 595, 609-612 (1984).

[36] Such concerns might have relevance, of course, if the patient were competent to express them. Where the patient is not competent, however, they become another example of imputing feelings and desires which may not in fact be present.



*Permanently Unconscious and Other Vulnerable Persons*, 3 Issues in Law & Med. 203 (1987). Many will come to the sensible conclusion that the withdrawal of nutrition and hydration from patients is morally indistinguishable from ending their lives by a lethal injection. *Id.* If there is a single phrase that crystallizes the issue in this case, it is this: "Doctors must not kill."[37] This fundamental maxim is placed in jeopardy by the relief sought here.

Removing food and water threatens the physician-patient relationship by creating the possibility, in any such relationship, that the physician's role may involve the intentional ending of the patient's life.

> Many physicians believe discontinuation of hydration would sever the therapeutic relationship irrevocably, while maintaining hydration would reinforce the traditional goals of the physician-patient relationship: To cure sometimes, to relieve occasionally, to comfort always. Physicians would also be spared the direct causal responsibility for the death of the patient and the inevitable associations of this practice with active euthanasia.
>
> Siegler and Weisbard, *Against the Emerging Stream*, 145 Arch. Intern. Med. 129 (1985).

The clear object of the petition here is to end the life of Ms. Cruzan, an intent which is inimical to the very nature of medicine. The removal of the feeding tube has no effect other than to cause Nancy's death; thus, the act is morally indistinguishable from lethal injection.

Ironically, *amicus* AMA does not see the internal inconsistency of its position on this point. At one point in Opinion 2.18 of its Judicial Council, the AMA states that "[the physician] should not intentionally cause death." Yet, later in that statement, and more fervently in this case, it argues that intentional starvation of a patient is ethically permissible. The inconsistency is palpable. But even if the point is arguable, does this not point out the

[37] *See*, Gaylin, Kass, Pellegrino, and Siegler, *Doctors Must Not Kill*, 259 J.A.M.A. 2139 (1988).

wisdom of a public policy that defends the most basic maxim of medicine, not only by outlawing those actions which unarguably constitute physician killing, but also those actions which most probably do so?

Certain *amici* answer this question by stating that the removal of food and water does not cause the death of the patient, but that death is due solely to the underlying disease. Brief of AAN at 23-24. This argument is unpersuasive. The comatose or vegetative patient is unable to swallow, but it is sophistic to say that this particular disability is the cause of death. Even if Nancy Cruzan could *swallow*, she would be equally incapable of *feeding* herself—as are thousands of citizens with severe and profound disability. The condition that necessitates assistance in feeding is the coma itself—not the mere inability to swallow. The logical inference is that there is no obligation upon society or the medical profession to maintain the nutrition of patients in such conditions. While the argument is couched in terms of tube feeding, it would seem equally applicable to spoon-feeding, which is equally useless at reversing the underlying medical condition. For a physician or any health-care provider to abandon this form of treatment for reasons unrelated to the burdensomeness of the treatment is to dilute that provider's commitment to the life of the patient.

This Court should also recognize that its decision holds ramifications for society's treatment of various categories of dying and disabled patients.

> We have deep concerns about accepting the practice of withholding fluids from patients, because it may bear the seeds of unacceptable social consequences. We have witnessed too much history to disregard how easily a society may disvalue the lives of the "unproductive." The "angel of mercy" can become the fanatic, bringing the "comfort" of death to some who do not clearly want it, then to others who "would really be better off dead," and finally, to classes of "undesirable persons," which might include the terminally ill, the permanently unconscious, the severely



> senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps, the aged.

Siegler & Weisbard, 145 Arch. Int. Med. at 130-131.

A small but decisive step in this direction is found in some of the arguments on behalf of the Petitioner. The Brief of the American Academy of Neurology, for example, argues that "[a] physician's duty aggressively to promote the well-being of a patient presumes that some chance of improvement or recovery remains." [38] This is medical ethics turned upside down. The obligation of the physician to the comatose, vegetative, or developmentally disabled patient does not depend upon the prospect for recovery. The physician must always aggressively act on behalf of the patient's well-being. This mandate does not require the use of all therapies or treatments to sustain life for an incurable patient, but it does proscribe the relative valuation of a patient's life that is implicit in the AAN brief.

The Missouri court provided an adequate answer to the AAN argument:

> The medical argument, if carried to its natural conclusion, takes us into a dangerous realm; it seems to say that treatment which does not cure can be withdrawn. But "[w]hen we permit ourselves to think that care is useless if it preserves the life of the embodied human being without restoring cognitive capacity, we fall victim to the old delusion that we have failed if we cannot *cure* and that there is then, little point to continue *care*."

760 S.W.2d at 423 (citations omitted).

The AAN's remarks in this regard are so startling, and so contrary to the ethic which defines medicine as a profession, one must assume that sympathy for the plight of Nancy and the entire Cruzan family led to statements which simply could not be defined in a more neutral setting. Yet, extravagance and suspension of judgment are a significant risk in any case of this type, where the im-

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[38] Brief of *Amicus Curiae* American Academy of Neurology at 13.

pulse of mercy confronts the natural instinct to preserve life. The state is not the perfect arbiter of such conflicting values, nor perfectly innocent of excess in rhetoric. However, state courts are a vital mechanism—though not the exclusive one—of bringing the values of the community to bear upon such decisions. In this case, the Missouri Supreme Court cogently and rationally balanced the competing interests at stake, and accurately reflected the true nature of the obligation to patients in the PVS.

## CONCLUSION

This appeal does not concern the prolongation of Ms. Cruzan's life, regardless of burden, expense or futility. It does, however, concern society's obligations toward its most vulnerable citizens, and particularly, whether "mercy-killing" or euthanasia of such patients will become protected as a constitutional right.

Enduring principles of law and medical ethics do not make the tragedy of Ms. Cruzan's condition easier to bear or to understand, but they do provide sure guidance for the decision of this Court. The relief sought here—to intentionally cause Nancy Cruzan's death by denying nourishment to her—finds no support in the common law, or in the substantive due process decisions of this Court. Furthermore, constitutionalization of this issue threatens to upset well-established principles of guardianship law, and foreclose the ongoing resolution, in Congress, state courts and legislatures, of the complex medical, moral, social and economic issues posed by the long-term care of patients such as Nancy Cruzan.

For the foregoing reasons, your *amici* respectfully request that the decision of the Supreme Court of Missouri be affirmed.



Respectfully submitted,

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## APPENDIX

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